Mental Disorders of the Aged

The Role of the State Hospital in the Treatment; Report of a Pilot Study

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• **The number of patients age 65 and over at the Agnews State Hospital now constitutes over one-third of the resident population. The geriatric population is increasing in all California state hospitals.**

Because this is a relatively new area of concern for the psychiatric institution, the role of the state hospital in the care of the aged is not yet clearly defined.

A pilot study of admissions in this age group committed from one county during a 12-month period was undertaken, with an attempt made to evaluate the suitability of the patient for commitment, as well as special problems in admission, treatment during hospitalization, and release from the hospital. The study indicated 42 per cent of persons admitted were considered unsuitable for commitment. Physical illness was found to be a major factor in precipitating admission and a predominating factor in the treatment program after admission. Almost 40 per cent of the patients died within a year after admission.

IT HAS BECOME URGENT to clarify the role of the state psychiatric hospital in the care of senescent patients with mental disorders as the number of patients in the older age group increases. The magnitude of the problem is indicated in a report by the Department of Mental Hygiene in 1959[3] stating that the number of patients, aged 65 and over, in California state mental hospitals had increased from 18 per cent of the total hospital population in 1941 to over 30 per cent in 1957. Current statistics indicate the proportion of patients within this age group at the Agnews State Hospital is over 39 per cent.

It is assumed that the criteria for commitment for the elderly patients should be essentially the same as for the younger patients—that is to say, persons with harmless chronic mental illness should not be confined to a state institution. The Department of Mental Hygiene in the past several years has reinforced this concept by communications to boards of supervisors, superior court judges, district attorneys and others, stating, for example: "An aged person who merely suffers from loss of memory, is childish, irritable, restless, careless in toilet habits, or in need of hospitalization for physical ailments is not qualified for state hospitalization. On the other hand, an elderly person who is markedly delirious, depressed, destructive, paranoid or threatening, may be properly considered for commitment to a state hospital."[4]

Previous studies have been widely discrepant in estimation of geriatric patients unnecessarily committed to state hospitals.[2,6] We accordingly decided to undertake a pilot study of patients committed from one county, in an attempt to obtain information on the following general questions: (1) How many geriatric patients were inappropriately committed? (2) What factors other than senile mental changes tend to precipitate commitment? (3) What efforts are made at the community level to avoid commitment? and (4) What are some of the problems in getting the inappropriately committed patients back to the community?

The selection of the particular county surveyed in this report was based on several reasons. The county was close enough to the hospital to facilitate communication, and had already expressed interest in closer liaison in the after-care of non-geriatric patients through the services of the county hospital. It has a wide range of programs in the area of health and welfare services. Finally, the selection was made because a statistical report from the Department of Mental Hygiene for the fiscal year 1958 revealed that a relatively high proportion of the total number of patients sent from that county for that year were geriatric patients—24 per cent as compared with a state average of 14.8 per cent.[5]

A schedule was developed on which items of information were entered for each patient, 65 years of age or over, entering the hospital from that county from February 1, 1959, through July 31, 1959. In addition to certain identifying information, the medical psychiatric diagnosis by the county and by the hospital were entered. The

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principal point of information, however, was the description of the patient's behavior and physical and mental status given by the county as the basis for requesting care in a state mental hospital, and the same kind of statement entered in the patient's chart by the hospital at the time of, and following, admission. In addition to this, the continued observation of the patient was noted by other staff physicians and psychiatrists as the patient moved from admission service to the various wards. Each of the patients, after summary of the above data, was placed in one of the four classifications:

1. *Concur:* The observation and evaluation of the patient by the hospital medical staff was essentially the same as the evaluation and description given by the county as the basis for commitment.

2. *Non-Concur:* The patient did not present the kind or degree of symptoms or behavior as described by the county nor the kind or degree of symptoms and behavior to qualify the patient for commitment to a state hospital.

3. *Doubt:* Patients in which the question of appropriateness of the commitment was not clear. This classification was included in order to provide the fullest opportunity for conservativeness in the evaluation. That is, while the patient did not appear to present the degree of symptoms or specific evidence of behavior to qualify for admission to a state hospital, there was some basis for the hospital personnel being hesitant, at that time, to say the patient could be cared for in a non-psychiatric facility.

4. *Not Classified:* This category was established for those cases not pertinent to the purposes of this study—commitment for alcoholism or the occasional voluntary admission are examples.

The age range for the classified patients was 65 to 89 years. The median age was 75. Fifty-five patients in the selected age group were admitted from this county during the first six-month period. Eight were not classified for reasons previously noted. As to the remaining 47 patients, the hospital concurred in 15 instances (32 per cent) with the county's basis for requesting hospitalization. In eight cases (17 per cent), there was basis for doubt. Two instances of statements forwarded by the county compared with the statements of the state hospital staff with respect to those patients, where there was "nonconcurrence," should serve to illustrate the material on which this classification was made.

Patient 1. A woman 75 years of age

County Descriptive Evaluation

Management problem in nursing home. Nearly blind. Belligerent and has been under heavy sedation. Nursing home reports patient fights with other patients and staff with fists. Gets into others' belongings. Is insulting. Heavy sedation at home possibly injurious to patient's physical condition.

Hospital Descriptive Evaluation

Bedridden due to emaciation and extreme weakness. Memory spotty. Cooperative and non-resistive. Disoriented for time and place. Patient will require continuous hospital care, chiefly for medical reasons. Seems principal reason for her "agitation" was probably her critical physical condition.

Patient 2. A woman 77 years of age

County Descriptive Evaluation

Has become progressively more confused and senile for past three years. Marked memory impairment, some speech difficulty, suspicious of surroundings. Becomes agitated and angry and has been uncontrollable. Episodes of marked hostility coupled with uncontrollable behavior.

Hospital Descriptive Evaluation

Patient appears pleasant and cooperative. Speaks in stuttering fashion and is rambling and repetitive. Disoriented and shows memory impairment. Physical condition appears good and patient ambulates well. Neatly groomed.

* * *

A comparison was made between the two types of admissions involved in this study—that is, by court commitment and by health officer application. In the latter instance, the procedures are less formal. Most important to the consideration of this study is the fact that the patient admitted by health officer application usually has not been in residence in the psychiatric ward of the county hospital. Therefore the diagnostic and evaluative work may not be as comprehensive or the criteria as uniform. It would be anticipated that a substantial portion of the inappropriate admissions to the state hospital would be by way of the health officer application, on the assumption that county hospital criteria as to need for state hospital care would more consistently approximate the criteria of the Department of Mental Hygiene. In the group of patients in this study, this was not the case. Of the mentally ill court-committed patients 50 per cent fell into the *non-concur* classification, whereas 53 per cent of the patients admitted by health officer application were in this category.

A second part of this study was done in 1961. It consisted of a review of the admissions from the same county for the six months of August 1, 1959, through January 31, 1960, with classification as in the first six-month study. During the interval between these two parts of the study, attempts were

made to establish better contact with the public health authorities of the county, both through efforts of the Department of Mental Hygiene Bureau of Social Work located within the county, and directly from the hospital. Several meetings were held between county and state hospital administrative staff in an effort to clarify the mutual responsibility of caring for the senile patient. Tabulation of the data on the second six-month period therefore was undertaken also as a possible indication as to whether the effort to improve county-state hospital communications had helped to bring about better agreement as to the type of patient suitable for commitment.

There were 39 patients 65 years of age or older among the patients committed from the county from August 1959 through January 1960, voluntary and alcoholic commitments excepted, as in the first group. Classification of these cases was as follows: 15 cases (38 per cent) were rated *concur*, 12 cases (31 per cent) *doubt* and 12 cases (31 per cent) *non-concur*. In other words, although the percentage in which there was agreement between the county authorities and the hospital staff regarding the need for commitment remained virtually the same (31 per cent and 38 per cent), the number of cases where the notes of the hospital staff seemed clearly to deny the need for commitment dropped from 51 per cent in the first six-month group to 31 per cent in the second. However, the *doubt* group was larger. For the most part the patients so classified were described as noisy at night, verbally abusive or delusional but were physically disabled to the degree they could not be considered a danger to anyone. The state hospital staff and the county physicians appeared to agree on the description of these patients but differed in opinion as to the place in which the necessary total nursing care should be administered. We concluded that the efforts made during the first six-month study had resulted in somewhat better understanding on the type of patient for commitment.

On final résumé of the 86 admissions from the selected county during the 12-month period spanned by the first and second parts of the study, there were 30 cases (34 per cent) in which there was agreement as to the need for commitment, 36 (42 per cent) in which the hospital staff felt the patient's condition was such that the proper supervision and care could be provided elsewhere, and 20 (23 per cent) in which the need for commitment seemed doubtful.

Thirty-four (39.6 per cent) had died within the follow-up period of one year after admission (there were seven additional deaths among the group for which an 18-month follow-up was available). The median length of time in hospital from admission to the time of death was between two and three months. Six patients died within two weeks of admission and 11 within four weeks. Causes of death given by the attending ward physicians did not differ significantly from those listed for the hospital geriatric population generally, pulmonary infection and cardiac disease being listed most frequently, with urinary tract disorder and uremia given in three of the male patients as principal cause of death.

Fourteen patients were subjected to major surgical procedures, including nine open reductions of hip fractures. A serious medical problem, exclusive of terminal illness, occurred in 43 patients (50 per cent). Included here were diabetes, acute cardiac decompensation, pneumonitis, acute cellulitis, massive rectal bleeding and glaucoma. In addition there were numerous minor physical illnesses and x-ray and laboratory or other diagnostic work-up which were not tabulated in detail. The strain of the increased number of illness-prone and accident-prone elderly patients on a budget of sixteen dollars per patient bed per year (at the time of survey) for all medical and surgical supplies was great. In this regard we would add parenthetically that 50.6 per cent of all major surgical procedures done at Agnews in 1961 were on patients age 65 or over.

The schedule for tabulation of information on the total group called for comparison of the psychiatric diagnosis given by the county and later by the hospital staff; the same was planned for physical diagnosis. This could not be done however, because of disparity of terminology in the psychiatric diagnosis, the county physicians jotting down "CBS" [for "chronic brain syndrome"] or "senility" or "senile psychosis" in the usual case. Sometimes no diagnosis was offered—a descriptive phrase being substituted, such as "broke window," or "antagonistic and combative." This is probably explained by the fact the examining physicians are unfamiliar with the official psychiatric diagnostic terminology, as there appeared to be generally good agreement when patients were committed through the county hospital, where a psychiatrist made the diagnosis. The county psychiatric staff tended to favor the diagnosis "chronic brain syndrome with senile brain disease with psychotic reaction," while the state hospital staff more often preferred the qualifying phrase, "with behavioral reaction." Again the physical condition was often described by one word or a brief phrase such as "fair," "good," "senile," "essentially negative," "heart and lungs negative," "anemia." In some instances it was felt that a definite hardship to the patient had resulted from just this lack of information when acute symptoms developed after hospital admission that might

have been prevented if more information regarding diagnostic work-up, medication, and the like had been forwarded with the patient.

At the time of admission, three patients were found to have blood sugar content so high that treatment was needed. Eleven were severely hypertensive. In one a toxic thyroid nodule was noted, and one patient had acute pneumonitis. There were notations of generalized edema in three patients, prostatic hypertrophy with elevation of the blood urea nitrogen in three, signs of cardiac decompensation in seven. Nine patients were noted to be too feeble to stand. One had carcinoma of the lung with metastasis. Another was comatose on arrival and died eight days later.

At the end of the year follow-up period, 18 patients had been placed on leave of absence or discharged from the hospital. The number of leaves was essentially the same for the *concur* groups as the *non-concur*. Four of the 18 patients on leave were returned to the hospital, two then being released again. Among the patients successfully placed on leave, ten were discharged to their families, one went to another county hospital, six were placed in nursing homes through the joint endeavors of the hospital social service staff and the patient's family. Of these six, four had been in nursing homes before commitment, suggesting that further assistance to the family from a trained social worker in locating a nursing home more in keeping with the patient's needs might have avoided commitment had it been offered at the county level. There was no difference in the number of patients who had previously been tried in a nursing home in the *non-concur* group as compared with the *concur* group.

DISCUSSION

Although it seems possible the particular county chosen for study uses the state hospital as a resource for the severely disabled more than some of the other counties committing to Agnews, the observation regarding these cases has been pretty general with regard to elderly patients admitted to Agnews, in that almost without exception the symptoms and behavior changes exhibited are those of severe, incapacitating mental confusion and disorientation. One reads a great deal about enthusiastic plans for "senior citizen" programs and the prevention of deterioration by recreational and socialization facilities, all of which may be valuable with another group of elderly persons, but the patients in the over 65 age group admitted to Agnews are almost overwhelmingly in need of total supervisory care, with the attention of the psychiatric ward personnel directed toward dressing, bathing and feeding patients who are too feeble physically or too disorganized mentally to help themselves adequately. For example, out of the total group of 86 reviewed in this study, only one was well enough to attend an off-ward occupational therapy clinic.

This study tends to confirm that physical illness as a factor in precipitating commitments is of major importance, as has been suggested in other studies.[1,7]

It was felt there were problems associated with planning of release for the elderly patients which differed in many respects from that for younger patients. Members of the state hospital staff frequently express concern about a suggestion for moving an aged and infirm person. Families of elderly patients are often reluctant to remove the patient when they observe that good medical and nursing care is being provided. Understandably, they are not concerned with the technicalities which distinguish eligibility for one type of facility from that of another. Among the few, rather standard, possibilities for placement of an elderly patient from the state hospital, the private, licensed nursing home is the most prominent. Here, as in other types of care, a range of eligibility requirements must be considered. The psychiatric diagnosis of a patient is an ever-present consideration even though the patient has become relatively symptom free. Nursing homes are rarely equipped to care for patients presenting behavior-management problems. Confused wandering or collecting the belongings of other patients are examples of unacceptable behavior. Other facilities, such as homes licensed for "light mental" patients are limited in number and vary widely in eligibility requirements based on age, sex, veteran status, and the like. Most facilities, whatever their nature, are relatively expensive and beyond the means of many elderly state hospital patients or their families. When county financial assistance is indicated, there may be additional requirements to be met, such as county residence or competence of the patient, and guardianship. Then, too, counties differ in their policies with respect to expenditure of local funds. All in all, a patient can be disqualified for placement quite easily when faced with a complex constellation of limitations on eligibility.

A comment is in order here with reference to the general consideration of care of confused elderly persons. Whether the patient is one with a geriatric mental disorder in which the intellectual impairment is minimal or has a profound degree of deterioration, there appear to be factors in the environment which can be therapeutic, with the goal either social rehabilitation and release from the hospital for the less impaired patient, or the more modest achievement of reduction in emotional turmoil, restlessness, hostility and agitation in the more

seriously damaged patient. This is brought home most forcefully by the fairly frequent occasions in which a patient will do very well in the hospital, then undergo a recurrence of behavior disturbance when placed in a rest home or smaller institution, and again improve on return to the state hospital. A similar impression is often volunteered by members of the family as a reason for reluctance to take part in release plans again.

Informal survey among physicians, social workers, and nursing supervisors has consistently elicited opinion that certain nurses or psychiatric technicians excelled in working with senile patients, but there is no ready consensus as to what the effective personality characteristics of these individuals are. The nursing personnel in charge of wards generally rated as successful in maintaining a good milieu for the elderly patient were often quite unable to formulate any specific impressions about procedures or attitude conducive to improvement in the geriatric patient. However, we feel that some of the traditional routine of the state hospital, often that which is most objectionable to the younger patients, seems beneficial to the confused older patient. This adherence to routine has evolved from the necessity of "processing" large numbers of individuals through various daily activities such as meals, bathing and dressing, dispensing of medicine, store orders, mail and the like. The repetition of the activity at the same time and in the same manner, in the company of a large group of other patients, seems to be supportive to the confused elderly person. Other measures are the cultivation of an unhurried approach in dealing with the patient and the recognition of the patient as an individual with identity, while continuing to prompt the maintenance of routine.

These are obvious or "common sense" observations and there are surely many less obvious factors which can be separated out as common denominators in the successful management of the mentally disordered elderly person.

All the evidence points to the need for many more facilities for the treatment of the geriatric patient, either in large public institutions or otherwise. The state hospitals for the mentally ill, with already tremendous experience in this field, should be able to offer guidance in the type of facility, personnel, and other treatment modalities which will be most effective. Further studies to elucidate the "ideal" are strongly recommended.

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